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CHAPTER IV
SURGERY: MUSCULOSKELETAL SYSTEM
CPT CODES 20000-29999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter IV
Surgery: Musculoskeletal System
CPT Codes 20000 - 29999

A. Introduction

The general guidelines regarding correct coding apply to the CPT codes in the range of 20000-29999. Specific issues unique to this section of CPT are clarified in the following guidelines.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, or ZZZ. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier. All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure.

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an
E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day of service which may be reported by appending modifier –25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier –25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding.

C. Anesthesia

With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia

procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration (CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

Injections of local anesthesia for musculoskeletal procedures (surgical or manipulative) are not separately reportable. For example, CPT codes 20526-20553 (therapeutic injection of carpal tunnel, tendon sheath, ligament, muscle trigger points) should not be reported for the administration of local anesthesia to perform another procedure. The NCCI contains many edits based on this principle. If a procedure and a separate and distinct injection service unrelated to anesthesia for the former procedure are reported, the injection service may be reported with an NCCI-associated modifier if appropriate.

D. Biopsy

In accordance with the sequential procedure policy, when a biopsy is performed in conjunction with any excision, destruction, removal, repair, or internal fixation procedure, the biopsy procedure is not to be separately coded assuming a diagnosis has already been established which makes the excision, destruction, removal, repair, or fixation procedure medically necessary. If the biopsy is performed at a different site and represents a significant, separately identifiable service, a biopsy service can be reported. For example, if a patient presents with an upper extremity fracture and, during an internal fixation procedure, it is determined to be medically reasonable to perform a bone biopsy of the iliac crest while under the same anesthetic, a separate service for a bone biopsy, with modifier -59, could be reported. If, however, through the same incision, a biopsy of the humerus was obtained, this service is not to be separately reported. In the circumstance where the decision to perform the more comprehensive procedure

(excision, destruction, removal, repair or fixation procedure) is dependent on the results of the biopsy procedure, the biopsy procedure may be separately reported.

Additionally, in accordance with the sequential procedure policy, when an arthroscopic procedure is followed by an open procedure at the same session, only the column one service is reported; generally, this would be the open procedure. If an arthroscopic service is performed at one site and an open procedure is performed at another, the arthroscopic service is reported with a modifier indicating that these services were performed at different anatomic sites (e.g., modifiers -RT or -LT, modifier
-59, etc.)

E. Fractures and/or Dislocations

1. The application of external immobilization devices (casts, splints, strapping) at the time of a procedure includes the subsequent removal of the device when performed by the same entity (e.g., physician, practice, group, employees, etc.). Providers should not report removal or repair CPT codes 29700-29750 for those services. These removal or repair CPT codes may only be reported if the initial application of the cast, splint, or strapping was performed by a different entity.

2. Casting/splinting/strapping should not be reported separately if a restorative treatment or procedure to stabilize or protect a fracture, injury, or dislocation and/or afford comfort to the patient is also performed. Additionally casting/splinting/strapping CPT codes should not be reported for application of a dressing after a therapeutic procedure. For example, if a provider injects an anesthetic agent into a peripheral nerve or branch (CPT code 64450), the provider should not report CPT codes such as 29515, 29540, 29580, or 29590. Similarly, a provider should not report a casting/splinting/strapping CPT code for the same site as an injection or aspiration (e.g., CPT codes 20526-20615).

3. CPT codes for closed or open treatment of fractures or dislocations include the application of casts, splints, or

strapping. CPT codes for casting/splinting/strapping should not be reported separately.

4. If a physician treats a fracture, dislocation, or injury with an initial cast, strap, or splint and also assumes the follow-up care, the physician cannot report the casting/splinting/strapping CPT codes since these services are included in the fracture and/or dislocation CPT codes.

5. If a physician treats a fracture, dislocation, or injury with a cast, splint, or strap as an initial service without any other definitive procedure or treatment and only expects to perform the initial care, the physician may report an evaluation and management (E&M) service, a casting/splinting/strapping CPT code, and a cast/splint/strap supply code (Q4001-Q4051).

For OPPS if a hospital treats a fracture, dislocation, or injury with a cast, splint, or strap as an initial service without any other definitive procedure or treatment, the hospital should report the appropriate casting/splinting/strapping CPT code. Payment for the cast/splint/strap supplies is included in the payment for the procedure reported.

6. An evaluation and management (E&M) service may be reported with a casting/splinting/strapping CPT code if the E&M service is significant and separately identifiable.

7. Different codes have been created for removal of internal fixation devices as a separate procedure and modification/removal of these devices in conjunction with other procedures. When a superficial or deep implant (buried wire, pin, rod) requires a surgical procedure to remove (e.g., CPT code 20670), and it is performed as a separate procedure, this service may be reported. On the other hand, when the service is necessary to accomplish another procedure involving the same area, it is not to be reported separately.

8. In accordance with the general policy on more extensive procedures, when a fracture requires closed reduction followed by open reduction at the same patient encounter (e.g.,

inability to accomplish the closed reduction), only the open reduction service is reported.

9. When interdental wiring (e.g., CPT code 21497) is necessary in the treatment of facial (or other) fractures, as part of a facial reconstructive surgery, or arthroplasty, it is included as part of the service; accordingly, a separate service using the CPT code 21497 is not reported. If reported with other head and neck procedure codes, it should be coded with modifier
-59, indicating a separate distinct service was performed. The medical record should reflect the nature of the separately identifiable service.

10. When it is necessary to perform skeletal/joint manipulation under anesthesia to assess range of motion or accomplish fracture reduction as part of another related procedure, the corresponding manipulation code (e.g., CPT codes 22505, 23700, 27275, 27570, 27860) is not to be separately reported.

F. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

3. When a tissue transfer procedure (e.g., graft) is described in the principal procedure code, a separate service is not reported for performing the tissue transfer service necessary to complete the procedure.

4. In situations where monitoring of interstitial fluid pressure is routinely performed as part of the postoperative care (e.g., distal lower extremity procedures with risk of anterior compartment compression), a separate code for monitoring of interstitial fluid pressure (e.g., CPT code 20950) should not be reported.

5. When electrical stimulation is used to aid bone healing, the appropriate bone stimulation codes (CPT codes 20974-20975) should be reported; the codes for nerve stimulation (CPT codes 64550-64595) are inappropriate for this service. If a neurostimulator is medically necessary for other indications (e.g., pain control), a separate service is reported, however, modifier -59 should be attached indicating that this service is distinct in that it represents treatment of different symptoms; accordingly the medical record should reflect the indication for the nerve stimulator. In addition, CPT codes 97014 and 97032 (physical medicine for electrical stimulation) are not to be reported in conjunction with the above listed codes by the surgeon.

6. Routinely, exploration of the surgical field is performed during a surgical session. Codes describing independent exploratory services are not to be reported when a more comprehensive procedure is being performed in the same area.—Specifically, an exploration code such as CPT code 22830 (exploration of spinal fusion) is not reported with other procedures involving the spine unless performed at a different site/different incision from the other procedure(s). If, for example, a cervical spine procedure was being performed, and, at the same operative session, a lumbar fusion was explored through a separate incision, the CPT code 22830-59 could be reported assuming the requirement for medical necessity was satisfied.

7. Debridements (CPT codes 11040-11042, and 11720-11721) are included in the surgical procedures conducted on the musculoskeletal system when debridement of tissue is in the

immediate surgical field of other than fractures and dislocations. If, however, tissue debridement is necessary for a more extensive area (e.g., concurrent soft tissue damage due to trauma), the debridement codes can be reported. In open fractures and/or dislocations, debridement of tissue due to the fracture should be separately reported using the CPT codes 11010-11012.

8. Grafts, such as CPT codes 20900-20924, are only to be separately reported if the major procedure code description does not include graft in its definition.

9. The CPT code 20926 is a general code for tissue grafting (e.g., paratenon, fat, dermis) to be used when the primary procedure does not include grafting and when another graft code does not more accurately describe the nature of the grafting procedure being performed. Accordingly, it should not be used with codes in which the graft is already listed as a part of the procedure or with other grafting codes (see Chapter III for other graft codes).

10. CPT codes 29874 (Surgical knee arthroscopy for removal of loose body or foreign body) and 29877 (Surgical knee arthroscopy for debridement/shaving of articular cartilage) should not be reported with other knee arthroscopy codes (29871-29889). Report G0289 (Surgical knee arthroscopy for removal of loose body, foreign body, debridement/shaving of articular cartilage at the time of other surgical knee arthroscopy in a different compartment of the same knee).

11. The NCCI has an edit with column one CPT code of 24305 (tendon lengthening, upper arm and elbow, each tendon) and column two CPT code of 64718 (neuroplasty and/or transposition; ulnar nerve at elbow). When performing the tendon lengthening described by CPT code 24305, a neuroplasty of the ulnar nerve is not separately reportable, but a transposition of the ulnar nerve at the elbow is separately reportable. If a provider performs the tendon lengthening described by CPT code 24305 and performs an ulnar nerve transposition at the elbow, the NCCI edit may be bypassed by reporting CPT code 64718 appending modifier -59.

12. Some procedures (e.g., spine) utilize intraoperative neurophysiology testing. Intraoperative neurophysiology testing (CPT code 95920) should not be reported by the physician performing an operative procedure since it is included in the global package. However, when performed by a different physician during the procedure, it is separately reportable by the second physician. The physician performing an operative procedure should not bill other 90000 neurophysiology testing codes for intraoperative neurophysiology testing (e.g., CPT codes 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95900, 95904, 95925-95937) since they are also included in the global package.

13. Drug administration services (CPT codes 90760-90775) are not separately reportable by the physician performing an operative procedure for drug administration during the operative procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report HCPCS/CPT codes C8950-C8952, 90772 or 90773 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. HCPCS/CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775) describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (HCPCS/CPT codes 90760-90775, C8950-C8952) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration

service (HCPCS/CPT codes 90760-90775, C8950-C8952) may be reported with an NCCI-associated modifier.

14. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (eg, needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

15. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.